

6. List all professional activities since the time of cancellation of your Kansas license. Account for all time and explain all gaps in professional activity. Attach an additional sheet if necessary. Include actual work address, not corporate headquarter's address.

Activity: _____ Employer (if applicable) _____

Location: _____ Dates: From _____ To _____
street city state mm/yy mm/yy

Activity: _____ Employer (if applicable) _____

Location: _____ Dates: From _____ To _____
street city state mm/yy mm/yy

Activity: _____ Employer (if applicable) _____

Location: _____ Dates: From _____ To _____
street city state mm/yy mm/yy

Activity: _____ Employer (if applicable) _____

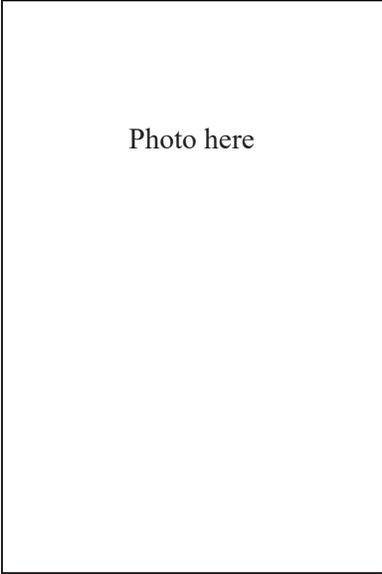
Location: _____ Dates: From _____ To _____
street city state mm/yy mm/yy

7. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a radiologic technologist. Attach an additional sheet if necessary. KSBHA will verify your credentials except for any state that does not provide free and current verifications on their official state website. For those states, you may complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held a radiologic technologist license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

State/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Photo.

Attach a **2"x 3" wallet size photograph** of applicant with head and shoulder areas only. The photograph must have been taken within 90 days prior to date of application. Proof photographs, negatives, copies of photographs, poor quality, photographs cut from books, newspaper articles or passport photos are **NOT** accepted.



9. Oath must be signed by applicant and notarized.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice as a radiologic technologist in the state of Kansas and may subject me to a fine not exceeding \$10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

Signature of Applicant

Sworn to before me this _____ day of _____ 20 _____

SEAL here

Notary Public

Commission Expires

10. Continuing Education.

Include proof of completion of continuing education as required by K.A.R. 100-73-8, if applicable.

Application fee of \$60 and NPDB report fee of \$3. Make the fees payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

Applicant Name: _____
(please print or type)



EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406ⁱ, please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ___ No ___ If yes:

Branch: _____ Dates of Service: _____ Military ID#: _____

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ___ No ___ If yes:

Branch: _____ Dates of Service: _____ Military ID#: _____

3. Do you currently reside in Kansas? Yes ___ No ___ If yes:

Current Kansas Residence Address: _____

4. Do you intend* to establish residency in Kansas within the next 6 months? **If you answer “yes” to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in KS and will be reported to all appropriate state/federal/military agencies in other jurisdictions.* Yes ___ No ___ If yes:

Intended Kansas Residence Address: _____

Expected Date of Commencing Residence: _____

If you answered “no” to all questions #1 through #4, you do not need to answer questions #5 through #7.

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. *This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.* Yes ___ No ___ If no:

a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes ___ No ___

b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes ___ No ___ If no:

Organization that issued private certification/registration: _____ Date Issued: _____



* “Active practice” does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.

6. Have you actively practiced* the profession for which you are seeking licensure in Kansas during the last 2 years?
Yes ___ No ___

If you answered “yes” to question #6, you do not need to answer question #7.

7. If you answered “No” to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

ⁱ An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public. K.S.A. 48-3406(d).



ATTESTATION QUESTIONS

Please answer each of the following questions. **All “yes” answers MUST be thoroughly explained in detail on a separate signed page.** You are required to furnish complete details including date, place, reason, and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the “yes” box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest “yes” answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest “no” answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the “no” box.

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes___ No___
2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes___ No___
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes___ No___
4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges? Yes___ No___
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility? Yes___ No___
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private? Yes___ No___
7. Have you ever voluntarily surrendered any professional license? Yes___ No___
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes___ No___
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes___ No___
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes___ No___



11. Has any professional association imposed any disciplinary action against you? Yes___ No___
12. Do you currently have any physical or mental health condition (including alcohol or substance use) that impairs your judgment or would otherwise adversely affect your ability to practice your profession in a competent, ethical, and professional manner? Yes___ No___
13. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances? Yes___ No___
14. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes___ No___
15. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? Yes___ No___
16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes___ No___
17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes___ No___
18. Have you ever been court martialled or discharged dishonorably from the armed services? Yes___ No___
19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes___ No___
20. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company? Yes___ No___
21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company? Yes___ No___

****It is your continued duty to update the Board on any changes once the application has been submitted.****



Third Party Authorization

Must be signed by applicant and notarized.

I, _____, hereby authorize all hospitals, institutions or organization, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas Board of Healing Arts or its successors any information, files or records requested by the Board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.

Signature of Applicant

Sworn to before me this _____ day of

_____ 20 _____

_____ Notary Public

_____ Commission Expires

SEAL here



LICENSE VERIFICATION FORM

Send to all states or jurisdictions in which you currently, or have ever, held a license, permit, or certification, permanent or temporary. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and email to KSBHA_Licensing@ks.gov or mail it directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of _____ having control of any documents, records, and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information including documents and/or records regarding charges or complaints filed against me or my license/registration; informal, pending, closed or any other pertinent information.

Full Name: _____

Other Names Used (if applicable): _____ Date of Birth: _____

License or Registration No.: _____ Issue Date: _____

Profession: _____

Signature: _____ Date: _____

Full Name of Licensee or Registrant: _____

License or Registration No.: _____ Status: _____

Issue Date: _____ Expiration Date: _____

License Method: _____ School: _____

DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? Yes ___ No ___ Unable to Divulge ___

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? Yes ___ No ___ Unable to Divulge ___

Comments: _____

Signature: _____ (SEAL)

Title: _____

State Board of: _____

Date: _____



THIRD PARTY RELEASE

If you would like the Kansas State Board of Healing Arts (“Board”) staff to talk with third parties about your application complete this form. This form provides authorization for the Board to release information regarding your application to third parties. This information includes, but is not limited to: application information, license verification, status change, address changes, Kansas Health Care Stabilization Fund information, continuing education information, audit information, and past or current legal issues and documents. This authorization expires one year from the date of signature. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. A reproduction of this authorization shall have the same effect as the original. Email to KSBHA_Licensing@ks.gov or mail it directly to the Board.

I, _____, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: _____
Phone: _____
Email: _____
Relationship: _____

2. Name: _____
Phone: _____
Email: _____
Relationship: _____

I acknowledge by my signature, that although I am not required to authorize the Board to release information to third parties, I am giving my consent for Board staff to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent, prior to my revocation.

Signature of Applicant

Date



GENERAL INFORMATION AND INSTRUCTIONS

Please visit www.ksbha.org for all statutes and regulations governing [Radiologic Technologists](#).

Thank you for your interest in becoming licensed in Kansas. Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. Do not make a commitment to any work dates prior to being licensed.

It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas State Board of Healing Arts (KSBHA).

One of the missions of KSBHA is public protection through effective licensure and enforcement. One way the public is safeguarded is by issuing licenses to fully qualified, competent and ethical applicants. You will be asked a series of attestation questions. A "yes" answer is not an automatic disqualification from licensure. All applicants are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to fully disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or "I did not think the prior act had anything to do with my profession or that it was still on my record or that it happened so long ago." There is no excuse for not disclosing.

Kansas Application Fees must be submitted with the application and are **NOT** refundable. Kansas application fee is \$60.00. Make checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card. To pay by debit or credit card please complete the credit card authorization form.

You must submit any change of address to the Board. Please visit our website to complete the "Change of Address" form.

Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas Board of Healing Arts.

The National Practitioner Data Bank (NPDB) Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. All applicants include a \$3 report fee for the Board to obtain the NPDB report.

Licenses/Certificates expire September 30 and are renewed annually. License renewal will be required of all receiving a permanent license prior to June 1.

CHECK LIST

Did you complete the following?

ALL questions answered on the application
Request verification from states, countries or jurisdictions, if applicable
Documentation for any "yes" Attestation Questions
Head and shoulder photograph
Notarize and sign Oath
Notarize and sign Release Form
Proof of continuing education, if applicable
Fees

revised 9/30/14, kl

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612

Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org



CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Please enter required information, sign and date at the bottom. Email or Mail form.



CARD NUMBER

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Verification Code

3-4-digit non-embossed number found on the card signature panel

Expiration Date

MO YR

____ / ____

Name (as it appears on the credit card): _____

Billing Address: _____
Street City State Zip

Telephone Number: _____ - _____ - _____

Payment Amount \$ _____ Purpose of Payment: _____
(e.g. renewal, application)

Applicant/Licensee Name: _____

I agree to pay the above amount per the card issuer agreement.

Signature _____ Date _____

Please Note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.

office use only			